***PAUNAWA****: Isulat sa* ***MALALAKING TITIK*** *(UPPERCASE) ang pag fill-out ng form.*

OPD Number: **${opd\_number}** | LINE NUMBER: **#{$line\_number}**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| \*Surname/Apelyido:  **${last\_name}** | \*First Name:  **${first\_name}** | | | Middle Name:  **${middle\_name}** | Suffix (e.g JR, SR, III, IV):  **${suffix}** | |
| \*Complete Address: *(House/Lot Nos., Street, Subd., Sitio/Purok)*  **${complete\_address}** | | | | \*Barangay:  **${barangay}** | \*Municipality / City:  **${city}** | |
| \*Date of Birth (MM-DD-YYYY):  **${bdate}** | \*Age:  **${age}** | | \*Sex (M/F):  **${sex}** | \*Civil Status:  **${cs}** | \*Contact Number/s:  **${get\_contactno}** | |
| Philhealth PIN (If Applicable):  **${philhealth}** | Email Address:  **${email}** | | | Name of Mother:  **${mother\_name}** | Name of Father:  **${father\_name}** | |
| Name of Spouse (If Applicable):  **${spouse\_name}** | | If minor, responsible person/guardian:  **${minor\_guardian}** | | | | Relationship:  **${guardian\_res}** |

|  |
| --- |
| \*Chief Complain:  **${chief\_complain}** |

\*Doctor’s Note:

Assessment:

${list\_assessment}

Plan of Action:

${list\_plan}

Diagnostic Procedure:

${list\_diag}

|  |  |
| --- | --- |
| \*Date/Time of Consultation: | ${con\_date} |
| \*Temperature: | ${temp} |
| Blood Pressure (BP): | ${bp} |
| Height (HT): | ${height} |
| Weight (WT): | ${weight} |
| Respiratory Rate (RR): | ${rr} |
| Purse Rate (PR): | ${pulse} |

|  |  |
| --- | --- |
| \***Signs and Symptoms:**  (Please check if applicable) | |
| List of Symptoms | Date of Onset |
| ⬜ Abdominal Pain | \_\_\_\_\_\_\_\_\_\_\_\_ |
| ⬜ Altered Mental Status | \_\_\_\_\_\_\_\_\_\_\_\_ |
| ⬜ Animal Bite | \_\_\_\_\_\_\_\_\_\_\_\_ |
| ⬜ Cough | \_\_\_\_\_\_\_\_\_\_\_\_ |
| ⬜ Colds/Coryza | \_\_\_\_\_\_\_\_\_\_\_\_ |
| ⬜ Conjunctivitis | \_\_\_\_\_\_\_\_\_\_\_\_ |
| ⬜ Eating Disorder | \_\_\_\_\_\_\_\_\_\_\_\_ |
| ⬜ Fatigue | \_\_\_\_\_\_\_\_\_\_\_\_ |
| ⬜ Fever | \_\_\_\_\_\_\_\_\_\_\_\_ |
| ⬜ Headache | \_\_\_\_\_\_\_\_\_\_\_\_ |
| ⬜ Joint Pain | \_\_\_\_\_\_\_\_\_\_\_\_ |
| ⬜ Jaundice | \_\_\_\_\_\_\_\_\_\_\_\_ |
| ⬜ Loss of Smell | \_\_\_\_\_\_\_\_\_\_\_\_ |
| ⬜ Loss of Taste | \_\_\_\_\_\_\_\_\_\_\_\_ |
| ⬜ Muscle Pain | \_\_\_\_\_\_\_\_\_\_\_\_ |
| ⬜ Nausea | \_\_\_\_\_\_\_\_\_\_\_\_ |
| ⬜ Paralysis | \_\_\_\_\_\_\_\_\_\_\_\_ |
| ⬜ Rash | \_\_\_\_\_\_\_\_\_\_\_\_ |
| ⬜ Sore Mouth | \_\_\_\_\_\_\_\_\_\_\_\_ |
| ⬜ Sore Throat | \_\_\_\_\_\_\_\_\_\_\_\_ |
| ⬜ Shortness of Breath | \_\_\_\_\_\_\_\_\_\_\_\_ |
| ⬜ Vomiting | \_\_\_\_\_\_\_\_\_\_\_\_ |
| ⬜ Weakness of Extremities | \_\_\_\_\_\_\_\_\_\_\_\_ |
| ⬜ Others | \_\_\_\_\_\_\_\_\_\_\_\_ |

**${doctor\_name}**

${doctor\_position}

Reg. No. ${doctor\_regno}